

How many individuals with HIV disease receive some HOPWA support?

During the 1998 operating year, HOPWA grantees reported that about 48,990 persons living with HIV/AIDS and more than 24,900 family members received some form of housing assistance funded through the HOPWA program, including a large number who received a small, short-term payment that helped to prevent homelessness.

What services do HOPWA grants fund?

Grantees document that the programs operating through 1998 used about 70 percent of funds to provide housing assistance. Additionally, 22 percent of funds were used for related support services to help clients maintain independent living or to provide support in assisted living facilities and community residences. The remaining 8 percent was used by grantees and sponsors for administrative costs.

Why are HOPWA funds used for support services?

The use of funds for supportive services directly helps these individuals and families maintain their housing and access health care and other support that is available in the community.

Are individuals living with HIV disease protected from housing discrimination?

Yes. HUD's Secretary issued a Directive on HIV/AIDS to help ensure that all of HUD's programs are available in the community to assist clients, based on eligibility, and that appropriate actions are taken in response to housing discrimination against persons with HIV/AIDS. The Directive noted that it is illegal to discriminate against a person because of a real or perceived disability. HUD's Office of Fair Housing and Equal Opportunity(FHEO) stands ready to investigate cases involving individuals with AIDS or HIV infection, or individuals perceived to have AIDS or HIV infection, who have been subjected to discrimination in housing. FHEO's Office of Investigations will address these issues with and take immediate action, when required, to prevent homelessness or other serious harm. The FHEO Office of Investigations may be contacted at 1-800-669-9777, via any HUD office, or at Headquarters at 202-708-0836. The Federal Information Relay Service TTY number is 1-800-877-8339.

How are housing needs changing among HIV-positive individuals?

Grantees and sponsors report that an increasing proportion of new HIV infections are among individuals living in poverty. Many of these individuals and families will require housing assistance to access medical care and follow treatment regimens. Many persons in treatment are living longer and will also have ongoing needs for housing assistance. The Department works in partnership with each community to help assess their needs in this regard, to inventory existing resources, and to help plan for coordinated efforts on behalf of persons with HIV/AIDS.

How much unmet need for housing assistance is there?

Surveys of providers and residents have been conducted by AIDS Housing of Washington (AHW), a leading technical assistance provider. AHW indicates that currently an estimated 200,000 persons in the country with HIV/AIDS are likely to be in need of some housing support; perhaps one-fourth of all those in need are being assisted through the HOPWA program. It is essential that persons in need also be assisted under other available programs, including those funded by State, local and private sources.

Find out more about HOPWA at <http://www.hud.gov/cpd/hopwabon.html> or call the Office of AIDS Housing headquarters at 202-708-1934.

HRSA CareACTION

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HRSA CareACTION

PROVIDING HIV/AIDS CARE IN A CHANGING ENVIRONMENT

HIV/AIDS and Homelessness

Abridged from HIV/AIDS and Homelessness, John Song, M.D.

Introduction

It is difficult to answer the question, How many homeless people are there in the United States? precisely. The National Coalition for the Homeless estimates that over 700,000 individuals in America are homeless on any given night, and the National Law Center on Homelessness projects that 2,000,000 people are homeless in the United States over the course of a year (1). Many others may endure temporary, unstable housing. One study, extrapolating from data gathered in New York City, estimated that 7.4 percent of Americans (13.5 million people) have been homeless at one time in their lives (2).

Staying healthy is a monumental challenge for homeless individuals. Vulnerability to crime and the elements, lack of medication storage facilities and refrigeration, poor access to water and food, and general exposure to unsanitary living conditions are just a few of the problems regularly encountered by individuals living in unstable housing.

Scope and Prevalence

HIV is found in epidemic proportions among the homeless. HIV prevalence is estimated at 3.1 percent and above in homeless populations that have been studied compared to .3 percent in the general population (3,4,5,6,7,8). Since homeless people in general are less likely to be tested for HIV than housed individuals (9), these figures probably underestimate the scope of the problem.

High incidences of behaviors that place individuals at increased risk for HIV have been well documented among homeless populations. They include injection drug use (IDU) (10,11,12), needle sharing (13,10, 14,15), frequenting shooting galleries (16,14), high-risk sexual behavior (17,18), and exchanging sex for money or drugs (19,20).

Many individuals living with HIV disease experience homelessness or unstable housing sometime during their lives. In a Los Angeles study of 785 individuals living with HIV disease who were receiving services funded through the CARE Act or HOPWA, 65 percent of respondents said that they had been homeless at some point; moreover, 50 percent of those who were not homeless felt themselves at high risk of becoming homeless (21). A longitudinal evaluation of HIV-positive injection drug users in Baltimore found that 46.7 of the sample had experienced homeless (22).

Co-Morbidity

Several conditions appear to occur more frequently among persons with HIV/AIDS who are homeless than among those who are domiciled. Injection drug use is common among homeless people. Most studies find prevalence at between 30 and 40 percent (23), and some studies have demonstrated even higher rates (24,11). A study from San Francisco found that homeless individuals with HIV/AIDS were 8.5 times

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more likely than those who were housed to be infected with bartonella quintana, the bacterium that causes bacillary angiomatosis-peliosis (25). A New York study found that among HIV-positive individuals, those who were homeless had much higher rates of bacterial pneumonia (26). Another study in New York City found 21 percent of homeless individuals with HIV/AIDS to have syphilis and 43 percent to have antibodies to hepatitis B (8). Another study from the same city found that 37 percent of homeless injection drug users were hepatitis C seropositive (27). Finally, a Boston study reported that homeless persons were more likely to have esophageal candidiasis (17 vs. 9 percent) and disseminated TB (9 vs. 2 percent) as their AIDS-defining condition (28).

Generally, latent TB prevalence is also extremely high among homeless people with HIV/AIDS; studies have found prevalence rates ranging from 32 to 67 percent (4,8). Homeless people with HIV/AIDS are probably at greater risk of reactivating latent TB infection into active disease (8, 29).

Medical conditions common among homeless people that have implications for HIV disease include **malnutrition** (30,31,32)—critical since AIDS is associated with decreased caloric intake, malabsorption, weight loss, and loss of muscle mass (33). Recently, it has been shown that even small degrees of weight loss—as little as 5 percent over 4 months—is associated with an increased risk of opportunistic infection and death (34). **Respiratory infections** are common (31,35) in homeless populations; one study found that 14 percent of homeless adults had suffered from **influenza** the previous year (36). **Infestations** are also common among homeless persons given their exposure to unsanitary environments (35,32,37).

**HAB/Bureau of Primary Health Care
Project on Homelessness**

The HIV/AIDS Bureau and the Bureau of Primary Health Care at HRSA are sponsoring a project to explore HIV/AIDS care among homeless persons, in partnership with the Health Care for the Homeless (HCH) Clinicians’ Network and the National HCH Council. The sponsors convened a working group of consumers, providers, clinicians, researchers, advocates, and government representatives on March 19-20, 1999. Based on the group’s recommendations and existing medical research, the document *HIV and Homelessness*, from which this article was abridged, was created. It provides guidance to providers caring for homeless individuals living with HIV disease and addresses policy and ethical issues.

homeless people as well; one study found that homeless people were 6 times more likely to suffer from a neurologic condition than a housed individual (32). This condition is relevant because the neurologic manifestations and sequellae of HIV/AIDS are protean and numerous.

There are many conditions more common among homeless people that may have an impact on the choice and success of HIV/AIDS therapy. The prevalence of diabetes (39); hyper-choloesteremia (30); anemia (34); chronic gastrointestinal tract illnesses (31,32); liver and hepatitic diseases (32); drug use disorder (4,40), and mental illness (41,42) are all higher among homeless individuals than among the general population.

Mortality

A recent study from Boston found that HIV disease is the most predictive condition for mortality among all homeless people (44). Also, homeless people are less likely than the HIV-infected population as a whole to receive antiretroviral therapy (45,46,47,12). It is thus reasonable to surmise that mortality due to HIV disease among homeless people is not dropping as rapidly as it is among other population groups.

HIV Care: Access and Utilization

Testing. There are indications that many homeless people at risk for HIV are not tested (5,8,48). A large study of IDUs in New York City found that only 45 percent of homeless participants had ever been tested for HIV, compared to 58 percent of those who were housed (9). A shelter-based study—a study that reported HIV seroprevalence at 62 percent—found that only 18 percent of the participants had ever had an HIV test (8), and a study in San Francisco showed that only 25 percent of homeless individuals found to be HIV-positive had ever been tested (4). A Denver study demonstrated that only 77 percent of homeless participants who reported high-risk behaviors had received HIV testing (49).

Even if homeless people are tested for HIV they often do not receive their test results. Only 66 percent returned in a study in Atlanta (5) and 70 percent in New York (8). A study in New Haven found that only 23 percent of homeless people who had been tested in the past for HIV knew their serostatus (48).

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Who is Homeless?

Source: National Coalition for the Homeless

Age

A 1998 U.S. Conference of Mayors’ survey of homelessness in 30 cities found that children under the age of 18 accounted for 25 percent of the urban homeless population; unaccompanied minors comprised 3 percent. A 1987 Urban Institute study found that 51 percent of homeless individuals were between the ages of 31 and 50.

Families

Families with children constitute between 35 and 40 percent of people who become homeless (Shinn and Weitzman, 1996; U.S. Conference of Mayors, 1998).

Ethnicity

The ethnic makeup of homeless populations varies according to geographic location. According to the U.S. Conference of Mayors’ study of the homeless in 30 cities, 49 percent were African American, 32 percent Caucasian, 12 percent Hispanic, 4 percent Native American, and 3 percent Asian. People experiencing homelessness in rural areas are much more likely to be White; homelessness among Native Americans and migrant workers is also largely a rural phenomenon (U.S. Department of Agriculture, 1996).

Victims of Domestic Violence

Of 777 homeless parents interviewed in ten U.S. cities, 22 percent said they had left their last place of residence because of domestic violence (Homes of the Homeless, 1998).

Veterans

According to the U.S. Conference of Mayors’ survey of 30 American cities, 22 percent of the urban homeless population were veterans.

Mental Illness

Approximately 20 to 25 percent of the single adult homeless population suffers some form of severe and persistent mental illness (Koegel et al., 1996).

Addiction

There is no generally accepted “magic number” with respect to the prevalence of addiction disorders among homeless adults; the frequently cited figure of about 65 percent is probably at least double the actual rate for current addiction disorders among all single adults who are homeless in a year.

Employment

Approximately 25 percent of homeless individuals in the U.S. are employed (U.S. Conference of Mayors, 1998; National Coalition for the Homeless, 1997). In a median State a minimum-wage worker would have to work 87 hours each week to afford a two-bedroom apartment at 30 percent of his or her income, which is the Federal definition of affordable housing.

Care. Homeless people have less access to health care than housed individuals. A study of homeless individuals in Los Angeles, for example, found that 66 percent of the sample had no medical insurance and 56 percent had no regular source of care. Study participants had, on average, 2.9 physician contacts in a year. These figures are contrasted to a national poverty sample of housed people that reports 36 percent without insurance, 24 percent without a regular source of care, and 6.3 physician contacts a year (50). Meanwhile, a study of homeless individuals in Baltimore found that only 47 percent of men

and 30 percent of women could name a usual source of care (40). The Boston Health Study found that homeless people with AIDS had three times more difficulty accessing care than those with homes because of unmet needs (51). The AIDS Cost and Services Utilization Study (ACSUS) found that homeless people with AIDS were less likely to access care than similarly situated housed people (52).

There are other indirect indications that homeless people with HIV disease have poor access to care. For example, Health Care for the Homeless (HCH) clinics

nationally reported a 35 percent decrease in client insurance coverage in 1997 (53). The ACSUS study found that only 15.6 percent of homeless individuals with HIV/AIDS had any kind of medical insurance (52). The lack of insurance adversely affects access to HIV care (54, 55). In addition, injection drug use has been shown to predict less access to care (56). Yet, 78 percent of providers of care to homeless people with HIV/AIDS surveyed in an ongoing study found obtaining substance abuse treatment for their patients difficult (57). Indeed, many individuals are excluded from care because they are homeless (57); many providers in the Healthcare for the Homeless survey had difficulty obtaining general primary care (58 percent), sub-specialty care (73 percent), respite care (57 percent), and case management (48 percent) for their patients who were homeless.

Antiretroviral Therapy and the Homeless

Homeless individuals living with HIV disease receive antiretroviral therapy at lower rates than the general population. In Boston, only 18 percent of homeless individuals with HIV/AIDS eligible for HAART according to Department of Health and Human Services' guidelines were taking any antiretroviral therapy at baseline of study; of those, only 4 percent were on three or more drugs (46). A study from San Francisco found that only 8 percent of eligible homeless individuals were on HAART (45). A national survey on the housing needs of individuals with HIV/AIDS found that only 17 percent of homeless people eligible for HAART were taking these medications compared to 51 percent of housed people (12). In each case it is unclear to what extent individuals were being offered these therapies were refusing them, or were accepting but not taking them.

Adherence. Lessons learned from treating tuberculosis. The treatment of TB among homeless people has been well documented and may be illustrative for treating HIV disease. First, it has been demonstrated that there are high rates of non-adherence in terms of returning to have skin tests read (8,48). Numerous studies have also demonstrated that homelessness is

associated with non-adherence to TB prophylactic regimens, with completion rates between 11 and 55 percent (59,60,61). Non-adherence has probably contributed to the staggering rates of drug-resistant TB among homeless populations, with proportions between 19-60 percent being described (62,63,48). There are, however, experiences with TB prophylaxis and treatment that have improved adherence, such as using peer advisors and financial incentives (64).

Adherence in Medical Practice. Adherence to medical regimens is generally poor, regardless of diagnosis or patient demographics; studies on asthma, antibiotic use, and hypertension have found non-adherence rates of 40 to 50 percent (65,66). In general, factors that have been shown to increase adherence include less frequent dosing (65,67,68), and reduction of pill numbers (65). Provider factors that improve adherence include accessibility and trust (69,70), and listening ability (70). Patient factors that improve adherence include physical and mental capability to adhere (71,72), availability of material resources (70), and belief and understanding that the medications are helpful (73,68).

Certain characteristics that predict lower rates of adherence—active IDU and mental illness among them—are over represented among homeless populations (74,75). Moreover, certain factors demonstrated to predict adherence are not common among homeless people, such as the presence of a supportive family (68). However, although there are substantial problems that can negatively affect adherence among the homeless, available data indicate that homeless people can adhere to regimens successfully. For example, an observational study San Francisco found that 56 percent of homeless people with HIV disease were adherent to HAART 75 to 85 percent of the time (45). In Boston, 52 percent of 30 patients on triple therapy were able to achieve complete suppression of virus with undetectable HIV viral loads (46). Finally, a study in New York found that 71 percent of homeless participants on AZT reported adherence to their medications (8). But while homeless people with HIV/AIDS can be adherent to complicated medical regimens, they have less access to adherence support systems. More research is needed to understand the best mechanisms for supporting adherence

Housing and Adherence

Names have been changed to protect confidentiality.

Lawrence

In 1997, L. T. started antiretroviral medications, taking them for 6 months with diligence. During that time he was housed in a single residence hotel. When he became homeless again, however, he told me that he knew that he would not be able to take his medications as prescribed, and he did not want to take them for fear of resistance. For the last year, L. T. has been homeless and not taking medication. His CD4 count fell to 250 and his viral load climbed to over 300,000. He is aware that he may be in trouble medically. (Barry Zevin, M.D., San Francisco)

Samuel

Samuel is a 32-year-old man who entered our therapeutic community for alcohol abuse treatment. He had tested positive for HIV 2 years previously. His blood work was remarkable for a CD4 count of 410 and a viral load of 130,000. An antiretroviral regimen of AZT, Efavir and

Viracept was prescribed. It was stressed that Viracept had to be taken on a full stomach. We saw Samuel 2 weeks later and—among other things—reminded him to take Viracept after a full meal. He told us he was doing so, with the exception of Saturday and Sunday mornings. The shelter in which the therapeutic community was located served three meals on weekdays, but on weekends served only two meals a day – brunch (at noon) and dinner (in the evening). So on Saturdays and Sundays, Samuel took his morning Viracept on an empty stomach. (Elizabeth Lutas, M.D., New York City)

Sonya

Being housed and in a more stable situation—and seeing social and nursing staff on a regular basis—S.A. successfully recovered from rectal surgery and kept her regular follow-up appointments with me. In October 1997, almost 6 months after her initial visit and frequent subsequent visits,

I felt comfortable and eager to start antiretroviral therapy. She started AZT/3TC and Nelfinavir. The regimen caused her only minimal diarrhea, and after a month her viral load had decreased considerably to 16,000 and her CD4 had doubled. These results were encouraging, but after 3 months, her viral load was again over 300,000. S.A. disclosed to me that she had stopped the Nelfinavir after the first month because there were too many pills, and that very rarely would she take the 3TC or AZT. A few months later her CD4 count was 10, but we felt ready to attempt therapy again. With the assistance of the Bridge Project physician and other staff, we amplified and reinforced the message of adherence. Since May 1998, her viral load has been undetectable, and her last CD4 count was 240. I keep frequent visits with her . . . There are still many obstacles, however. Bridge Project housing, for example, is limited to 18 months. (Linette Martinez, M.D., San Francisco)

Dr. Song currently is a fellow in general internal medicine and in the Greenwall program in Bioethics and Health Policy at Johns Hopkins and Georgetown Universities. For a copy of the complete document, contact Kim Evans at 301-443-4405. References available upon request.

The Multiple Diagnosis Initiative

The RWCA SPNS Program and the U.S. Department of Housing and Urban Development Office of AIDS Housing are collaborating to serve multiply-diagnosed HIV-positive individuals threatened by homelessness.

Determining the actual number of people affected by homelessness, HIV/AIDS, mental illness, and substance abuse may be impossible, but estimates provided by the National Coalition for the Homeless (NCH) give an indication of the extent of the problem:

- *Up to 50 percent of persons with HIV/AIDS are expected to need housing assistance of some kind during their lifetimes (NCH Fact Sheet #9: Robbins and Nelson, 1996).*
- *Approximately 20-25 percent of the single adult homeless population suffers from some sort of severe and persistent mental illness. (NCH Fact Sheet #3: Koegel et al, 1996).*
- *Projections as to the extent of addiction among the*

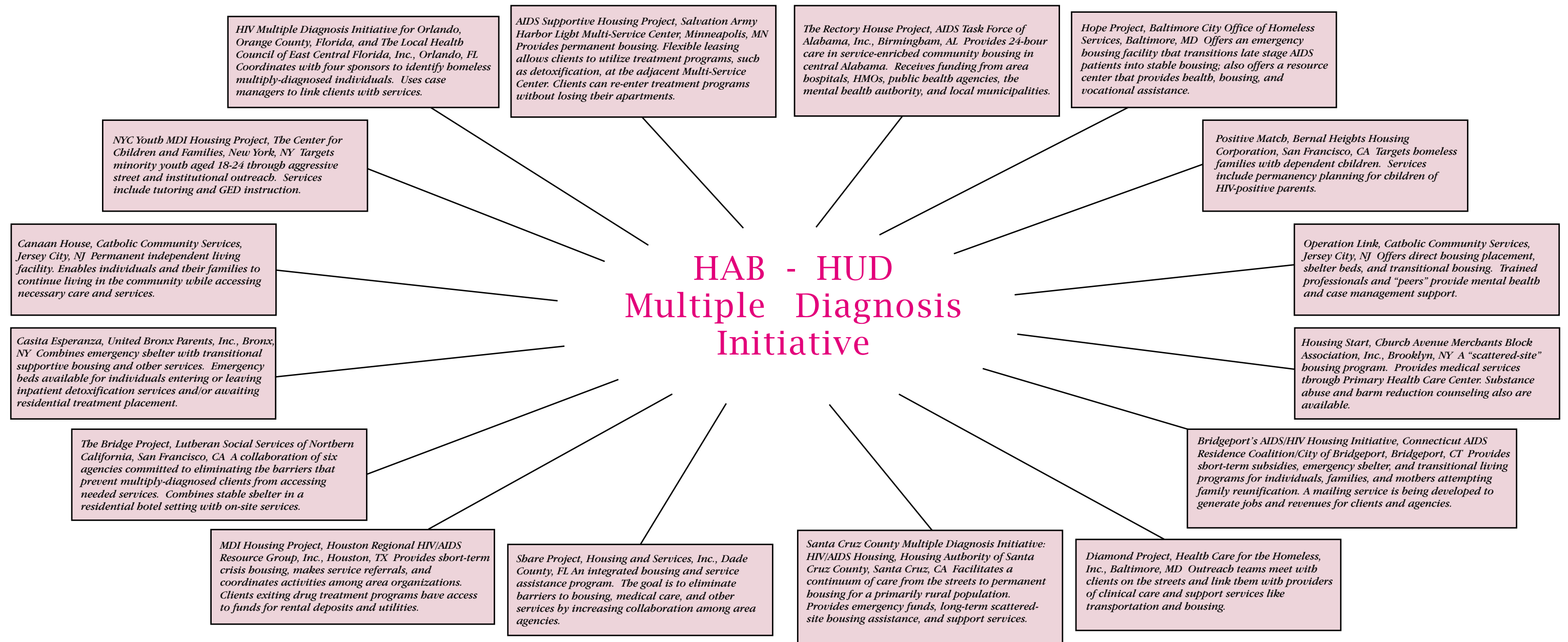
30 to 35 percent of the homeless population suffers some form of addiction (NCH Fact Sheet #6).

In response to complex needs of the homeless, multiply-diagnosed people with HIV disease, 16 projects are currently being funded through the Ryan White CARE Act Special Projects of National Significance Program.

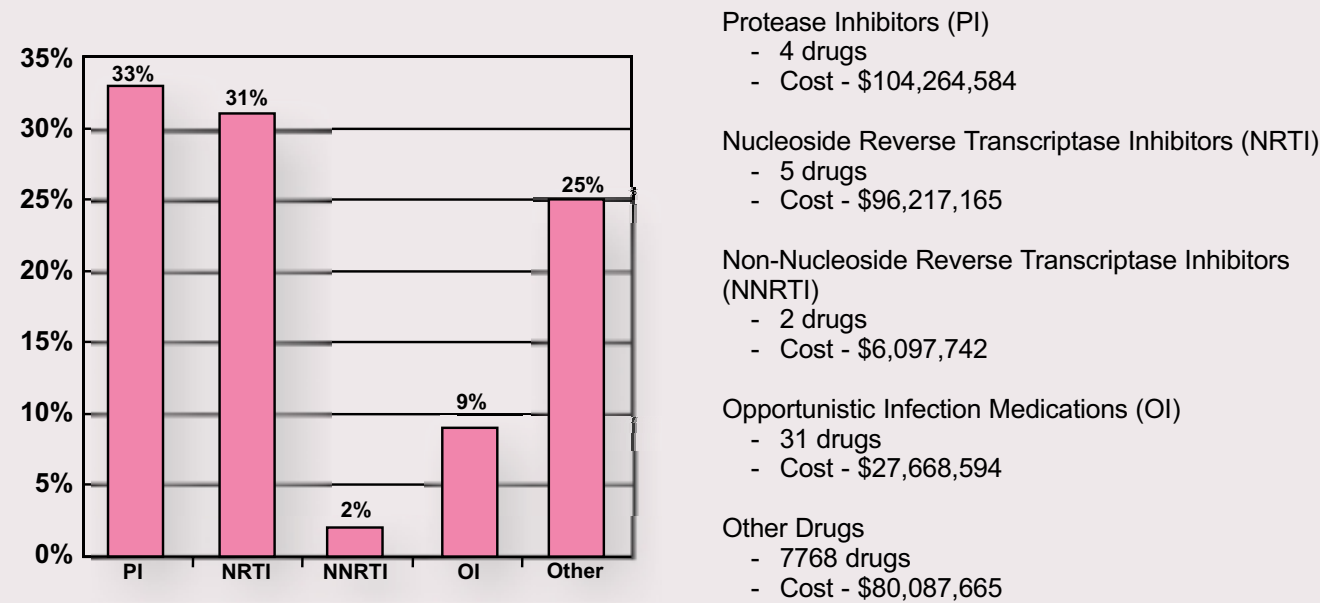
The 16 projects address issues closely linked to homelessness, substance abuse, and mental illness in individuals living with HIV disease. Many of these

grantees offer direct services that include housing, medical care, mental health care, substance abuse counseling, and case management. Others facilitate access to providers in the community. Some do both. All were awarded funding because they are innovative, replicable models of care.

Total funding for all 16 projects for the entire project period (which ranges from 3 to 5 years per grant) is \$22,000,000. Services have been provided to 2,500 clients over the past 2 years.



1997 State AIDS Drug Assistance Program Total Drug Expenditures by Drug Classification



Capacity Building in Minority Community-Based Organizations

HRSA Pilot Project Explores Approaches

HRSA's HIV/AIDS Bureau (HAB) initiated a technical assistance demonstration project this spring to identify methods of capacity building among minority community-based organizations. The Bureau and the National Minority AIDS Council (NMAC) teamed to conduct pilot workshops in Baltimore, Detroit, and Los Angeles. The effort supports the Congressional Black Caucus Initiative on HIV/AIDS and seeks to address infrastructure development needs of minority organizations.

A total of 113 service providers registered for the workshops, which focused on developing skills to maximize Federal, State, local and Ryan White CARE Act resources. Participants represented small-to-medium sized community and AIDS service organizations, health clinics, substance abuse and treatment clinics, housing facilities, and new agencies emerging to serve the needs of minorities. Agency budgets ranged from \$1,000 to \$863,000. Average budgets varied across the three sites: \$154,300 in Baltimore, \$202,700 in Detroit, and \$375,300 in Los Angeles.

"As more HIV resources are being made available to communities of color, we want to help organizations serving these communities to access funds and more effectively provide services," said Angela Powell-Young, Branch Chief of the Technical Assistance Branch in HAB's Division of Training and Technical Assistance. "These demonstration workshops helped us focus on areas where technical assistance is most needed and refine strategies for providing it."

Workshop sessions covered:

- An overview of the CARE Act from Federal and community perspectives;
- Accessing resources (fundamentals of accessing funds, how to write competitive funding proposals, and the grant review process);
- Fiscal management and oversight;
- Development and management of budgets;
- Budget and staff allocation; and
- Strategic planning as a tool for program planning, resource development, and fiscal management.

Participants' feedback was used to revise the agenda for the second two sessions and will be used to further refine training currently under development. Based on suggestions, HAB will:

1. Make the training as "hands on" as possible. For example, participants may bring samples of mission statements and goals and objectives for use in small group exercises, and use these sessions to apply what has been presented.

Place more emphasis on the goals and objectives

2. section of grant writing and the "big picture" overview of the entire grant writing process.

Identify appropriate technical assistance materials including information from local and national organizations or management and grant writing training.

For further information, contact Angela Powell-Young at 301-443-9091.

Understanding HOPWA

An Interview with David Vos, Director, Office of HIV/AIDS Housing, HUD

What is Housing Opportunities for Persons with AIDS (HOPWA) and when did it begin?

HOPWA is the Federal government's housing assistance program for low-income individuals living with HIV disease and their families.

Individuals living with HIV disease face severe personal health and financial problems, including finding or maintaining decent and affordable housing. Those in unstable housing conditions face serious barriers to adherence and regular medical care. For them, housing assistance is a gateway to HIV/AIDS care.

HOPWA provides several forms of housing assistance and essential support services. It was established in the AIDS Housing Opportunity Act of 1990 and funds were first appropriated for the program in 1992. Funds are made available by formula, based on AIDS statistics in metropolitan areas and States. The allocations are made to communities through a Consolidated Planning Process, which helps to ensure the involvement of citizens, area nonprofit organizations, housing and community development organizations, government entities, faith-based organizations, and other interested parties in each community. HOPWA funds are intended to be used in conjunction with other resources, including programs involving health care and supportive services for persons with HIV/AIDS under the Ryan White CARE Act and other Federal, State, local and private sources.

Who administers HOPWA?

HUD is responsible for administering HOPWA. The HOPWA program is implemented as part of the overall mission of this agency to provide a decent, safe, and sanitary home and suitable living environment for every American. HOPWA targets assistance to a population of persons with pressing needs and who are severely at risk of becoming homeless. As such, the program serves as one important tool with which communities can respond to local needs. The program also is integrated within six strategic objectives that cover all of the Department's housing and community development programs: fighting for fair housing, increasing affordable housing and homeownership, reducing homelessness, promoting jobs and economic opportunity, empowering people and communities, and restoring the public trust. In FY 1999, HUD received an appropriation of \$25.5 billion, including \$225 million for the HOPWA program, and the Department is working in partnership with States, local governments, and sponsoring organizations in providing a broad range of community development and housing programs.

Who receives HOPWA grants?

The statute provides that 90 percent of HOPWA funds are allocated by formula grants. In 1999, \$200.4 million was provided to 97 different jurisdictions: 63 cities and 34 States. The remaining funds are awarded by national competition to fund HOPWA Special Projects of National Significance programs as well as model programs in non-formula areas. In 1999, the program is authorized to use up to one percent of the funds to provide technical assistance to grantees and sponsors. Earlier in 1999, HUD announced the selection criteria and procedures that

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will include standards of care, treatment guidelines, dental services, programs for co-morbidities, population specific programs, and the impact of a managed care system on care and treatments. Workshops will highlight programs that have developed creative strategies for coordinating interventions into a system of care. The top five topics of interest identified by grantees are: adherence; clinical provider training; new therapies and related outcomes; clinical implications for underserved and hard-to-reach populations; and HAART -- compliance issues.

Policy and Finance

The topics of interest related to Federal and state policy and financing include: policy and financing implications of the shifts in the structure of social welfare delivery systems (e.g, Temporary Aid to Needy Families, Medicaid, managed care, Children's Health Insurance Program, etc.) and the impact on accessing and maintaining specific HIV infected populations in the care system -- specifically, racial or ethnic minorities, persons with substance abuse and/or mental health problems, and incarcerated persons; expanding access to HIV care via private and public programs (e.g., Medicaid, Medicare, and private health insurance); integrated health and social service networks and establishing/enhancing relations between CARE Act and other public/private funded programs; building infrastructure and capacity for HIV care services among traditionally underserved communities; local and national policy implications of the development and use of standard program and consumer outcome measures; and current challenges to the reauthorization of the Ryan White CARE Act. Other topics will be considered. The top five topics of interest identified by grantees are: data collection requirements - measuring outcomes; impact of demonstrated outcomes on funding levels; reauthorization; multiple funding streams and access to care/availability of services; and Medicaid managed care.

CALL FOR ABSTRACTS

*Ryan White CARE Act All-Title National Meeting
“Making a Difference: HRSA’s HIV/AIDS Programs”
Renaissance Washington DC Hotel
January 18-21, 2000, Washington, DC*

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The Ryan White CARE Act All-Title National Meeting presentations will be selected through a Call for Abstracts process. Persons who would like to present information relevant to the Ryan White CARE Act Titles or other HIV-related care programs are urged to submit abstracts for consideration. We encourage all CARE Act Grantees to consider submitting at least one abstract about successful or innovative practices in their areas.

Subjects presented at the Meeting must be relevant to the CARE Act Titles, cross-Title collaboration, and HRSA’s four guiding care principles:

- *Better serving the underserved in response to the HIV/AIDS epidemic’s growing impact among underserved minority and hard-to-reach populations;*
- *Ensuring access to existing and emerging HIV/AIDS treatments that can make a difference;*
- *Adapting to changes in the health care delivery system and the role of CARE Act services in filling gaps in care; and*
- *Documenting outcomes.*

Types of Presentation Formats:

- *Workshops are presentations of information and issues about specific topics in which skills will be developed by those in attendance. Workshop presenters should have statements of clear expected outcomes for the presentation. Workshops can either be interactive (format A) or didactic (format B) with time allowed for questions and answers. Workshops are two hours in length and may be conducted by an individual, co-presenters, or a panel. (See Abstract Submission Guidelines, last page).*
- *Roundtables are information presented on specific topics through informal conversation among small groups of ten individuals convened at round tables. Participants will typically attend two different one-hour roundtable discussions during the two hour session.*
- *Affinity Sessions are designed for a group of individuals interested in a common topic to meet, discuss, network, and share information about this topic. They are an hour in length and will be scheduled, per request, depending on space availability.*

- *Poster Presentations are visual presentations of subject matter in poster format display. Posters will be displayed throughout the meeting in the designated poster presentation exhibit area. Authors of posters may be available for discussion at their poster sites.*

Track Descriptions:

The meeting will consist of three tracks. The three tracks, in which all workshops, roundtables, affinity sessions, and poster presentations will be categorized, are:

1. *Administrative and Program Issues;*
2. *Clinical and Support Services; and*
3. *Policy and Finance.*

Each track is designed to provide Grantees an opportunity to share information and learn through interactive training. Please note that workshops, round-tables, seminars, and poster presentations must fall within the framework of the three tracks and the four Bureau principles. For each track, we have listed the top five topics identified by Grantees as being most important in response to our recent survey (these topics are indicated in italics in the descriptions of the three tracks) to assist you in the development of your abstracts. However, Grantees may choose any relevant topics.

Administrative and Program Issues

This track is designed to provide participants with the opportunity to share their skills and knowledge about evaluating and documenting program outcomes, data collection requirements for documenting progress in achieving goals, new and existing programmatic and legislative requirements, accessing training and technical assistance, and working with and addressing needs of underserved and hard-to-reach populations. Workshop presentations will demonstrate how cross-Title collaboration can enhance successful relationships to achieve common goals. Emphasis will be on increasing knowledge about processes and skills needed to achieve collaboration. The top five topics of interest identified by grantees are: program and services evaluation; assessing outcomes measures; assessment and quantification of unmet need; reaching the underserved; and impact of managed care on outcomes.

Clinical and Support Services

This track will address information on the latest developments in clinical care for HIV/AIDS, successful programs to treat hard-to-reach and underserved populations with the latest standards of care, and support services that enable the implementation of clinical standards of care. This track will provide participants with examples of programs which have enabled hard-to-reach populations to receive and be maintained in the latest clinical standards of care. Topics to be discussed

Abstract Submission Guidelines

Abstracts to be considered for presentation at the Meeting must be submitted on the attached abstract submission form in accordance with these guidelines. All information on the abstract submission form must be typed. Abstract title, presenter(s), and phone number and organization must be provided in the indicated space. All authors must be listed.* Abstracts may be typed directly on the form or printed on blank paper and cut and pasted onto the original form. Abstracts should be between 150 and 200 words (e.g., no more than one page). A font no smaller than 12 points should be used. No illustrations are permitted within the abstract.

The body of the abstract should conform to one of the following formats:

Format A:

- 1. Topic Description
- 2. Issues to be discussed
- 3. Learning objectives
- 4. Solutions, Methods, Models, or Examples

This format may be best suited for sessions designed to enhance skills building, frame discussions on HIV-related services delivery, policy, and maintenance, describe community based programs or interventions for bringing and maintaining hard to reach and underserved populations into care, describe a particular model or method of health services provision, and describe systems of health services delivery and care that include collaboration between programs funded under different Care ACT Titles and/or other PHS or other sources of funding. This format could be used for Workshops, Round-tables, Posters, or Affinity Sessions.

Format B:

- 1. Objective
- 2. Methods
- 3. Results
- 4. Conclusions

This format may be best suited for presenting scientific and research-oriented workshops and posters.

Programming for this Meeting will be based on this Call for Abstracts. Submission of an abstract implies a commitment to present at the Meeting if selected by the Steering Committee.

Because many popular sessions are offered concurrently, some presenters may be asked to repeat

Abstract selection criteria include the relevance to CARE Act titles and to people and families affected by HIV/AIDS, cross-title collaboration, HRSA's four guiding care principles, level of interest expected in the proposed session, and overall clarity of the abstract.

Abstracts must be received at the PSA office by August 13, 1999.

Notification of abstract disposition (whether the abstract was selected for presentation or not) will be mailed to presenters no later than September 30, 1999. Abstract dispositions will be sent to the presenting author ONLY.

Incomplete abstract submission forms and those not in accordance with the guidelines will not be reviewed or considered.

If you have any questions about this abstract form or instructions, please contact Elisa Luna at MOSAICA, the contractor assisting the HIV/AIDS Bureau (HAB) with this Meeting, at (202) 887-0620, Ext. 14, or Angela Powell, Chief, Technical Assiatance Branch, HAB, at (301) 443-6561.

*NOTE: Authors whose abstracts are accepted for presentation at the Meeting will receive further information on curriculum vitae and faculty disclosure requirements in order that presentations may be considered for CEU/CME credits.

Abstract #: _____
(Do not write. PSA use only.)

ABSTRACT SUBMISSION FORM
Deadline for Receipt of Abstracts: August 13, 1999
Ryan White CARE Act All-Title National Meeting

1a. Track: Adm and Pgm Issues ____ Clinical and Support Services ____ Policy and Finance ____

1b. Presentation Format Workshop ____ Roundtable ____ Affinity Session ____ Poster ____

Rank the abstract presentation formats you prefer from 1 to 4, with 1 indicating your first choice. Rank only those formats in which you are willing to present if your first choice is unavailable.

Are you willing to repeat your session if requested? Yes ____ No ____

1c. Abstract Title _____

1d. Primary Author _____

Author _____

Organization _____

Address _____

(Street) (City) (State) (Zip)

Telephone _____ Fax _____ E-mail _____

1e. Co-Authors (use additional sheets if necessary)

Name _____ Title _____

Organization _____

Address _____

(Street) (City) (State) (Zip)

Telephone _____ FAX Number _____ E-mail _____

Name _____ Title _____

Organization _____

Address _____

(Street) (City) (State) (Zip)

Telephone _____ FAX Number _____ E-mail _____

Name _____ Title _____

Organization _____

Address _____

(Street) (City) (State) (Zip)

Telephone _____ FAX Number _____ E-mail _____

Name _____ Title _____

Organization _____

Address _____

(Street) (City) (State) (Zip)

Telephone _____ FAX Number _____ E-mail _____

2. **ABSTRACT:** Follow one of the formats described in the Abstract Submission Guidelines
(Typed, minimum 12 Point font, 150-200 words):

Title _____ Primary
Author _____

3. Please indicate the type of audio-visual equipment that you require for your workshop presentation:

- _____ Overhead projector
- _____ 35-mm slide projector
- _____ LCD Projector (e.g., for connection to laptops for Power Point presentations)
- _____ Videotape player/monitor
- _____ Podium with Microphone
- _____ Table with Microphone

Note: Authors of abstracts selected for presentation will be advised of any problems with their audio-visual requests.

4. Submission Instructions:

- a. Mail to: Professional and Scientific Associates, Inc.
Attn: Bradley Rymph
6066 Leesburg Pike, Suite 200
Falls Church, VA 22041
- b. Or, fax to: Bradley Rymph, (703) 852-2901 (Telephone no. To call if you have problems with fax: 1-800-766-8635, EXT. 2914)

HRSA CareACTION CALENDAR OF EVENTS

JULY

- 7-9 *Message for the Millennium: Responding to the Many Voices of Change*
 Brooklyn NY
 Sponsor: Child Welfare League of America (CWLA)
 Contact: CWLA, 202-638-2952; Fax: 202-638-4004
 Web: www.cwla.org
- 8 *HIV Prevention Counseling: The Facts*
 Richmond VA
 Sponsors: VA Commonwealth U. HIV/AIDS Ctr.; Mid-Atlantic AETC, HIV/AIDS Bureau, HRSA; Central VA Resource & Consultation Ctr.
 Contact: VCU HIV/AIDS Ctr., 800-525-7605
- 11-14 *13th Meeting of the International Society for STD Research*
 Denver CO
 Sponsors: Intl. Society for STD Research; American STD Assn.; American Social Health Assn.; Natl. Ctr. for HIV, STD, and TB Prevention, Div. of STD Prevention, CDC
 Contact: ISSDR Meeting Secretariat
 201-947-5545, Fax: 201-947-8406
- 12-14 *Balm in Gilead's 1999 Training Conference: Partnering with Black Churches in AIDS Prevention and Service*
 Myrtle Beach SC
 Sponsor: Balm in Gilead
 Contact: Same, 212-730-7381; Fax: 212-730-2551
 Web: www.balmingilead.org
- 12-14 *Advances in Health Care Conference 1999: Pediatrics, Pharmacology, Emergency/Primary Care & Complementary Medicine*
 North Falmouth MA
 Sponsor: Nurse Practitioner Associates for Continuing Education
 Contact: Same, 781-861-0270; Fax: 781-861-0279
 Web: www.npace.org
- 12-16 *Tuberculosis Program Manager's Course*
 San Francisco CA
 Sponsor: Francis J. Curry Natl. Tuberculosis Ctr.
 Contact: Same, 415-502-4600; Fax: 415-502-4620
 Web: www.nationaltbcenter.edu
- 15-18 *AIDS Impact 1999: Connecting a World of Resources 4th International Conference*
 Ottawa, Canada
 Sponsor: Canadian Psychological Assn.
 Contact: AIDS Impact 1999, Canadian Psychological Assn.
 613-237-2144; Fax: 613-237-1674
 Web: www.cpa.ca or www.aidsimpact.com
- 15-16 *HIV Prevention Counseling: The Approach*
 Richmond VA
 Sponsors: VA Commonwealth U. HIV/AIDS Ctr.; Mid-Atlantic AETC, HIV/AIDS Bureau, HRSA; Central VA AIDS Resource & Consultation Ctr.
 Contact: VCU HIV/AIDS Ctr., 800-525-7605
- 16 *Nutrition Issues for HIV and Substance Abuse*
 New York NY
 Sponsor: Harm Reduction Training Institute
 Contact: Same, Sara Kershner, 212-683-2334
 Ext. 32, Fax: 212-213-6582
- 17-23 *24th Annual National Wellness Conference: The Wellness Connection... Experience It!*
 Stevens Point WI
 Sponsor: Natl. Wellness Institute, Inc.
 Contact: Same, 800-243-8694; Fax: 715-342-2979
 Web: www.wellnessnwi.org/nwc/
- 21-23 *Conference on the Role of Families in Preventing and Adapting to HIV/AIDS*
 Philadelphia PA
 Sponsors: Office of AIDS Research, Natl. Institute of Mental Health, NIH; U. of PA
 Contact: Loretta Sweet Jemmott, U. of PA
 215-898-6373, Fax: 215-573-9193
 Web: www.nimh.nih.gov/events/hivaids99.htm
- 21-23 *4th Annual National Prevention Institute*
 Seattle WA
 Sponsor: Comprehensive Health Education Fdn. (CHEF)
 Contact: Same, 800-323-2433; Fax: 206-824-3072
 E-mail: cbefstaff@chef.org
 Web: www.chef.org

July Continued

21-23 NAHN Annual Conference: Unidos Para Nuestra Comunidad (United for Our Community)

San Juan, Puerto Rico

Sponsor: Natl. Assn. of Hispanic Nurses (NAHN)

Contact: Same, 202-387-2477 or 800-662-7742

Fax: 202-483-7183

E-mail: nahn@juno.com

Web: www.incacorp.com/nahn

22-25 9th Annual Retreat for People Living with HIV: Celebrate the Past, Embrace the Present, Create the Future

Springfield VT

Sponsor: VT People with AIDS Coalition

Contact: Same, 800-698-8792 or 802-229-5754

Web: www.vtpwac.org

22-27 12th Annual National Catholic HIV/AIDS

Ministry Conference: Prophetic Voices

Chicago IL

Sponsor: Natl. Catholic AIDS Network (NCAN)

Contact: Same, 707-874-3031; Fax: 707-874-1433

Web: www.ncan.org

24-26 6th Annual Strictly Positive Wellness Conference: Into the New Millennium

Walt Disney World FL

Sponsors: Hope & Help of Central FL; FL AETC,

HIV/AIDS Bureau, HRSA; HUG Me

Program at Arnold Palmer Hospital

Contact: Michael W. Fuchs, Hope & Help of

Central FL 407-645-2577

Fax: 407-645-1570

24-28 1999 National Conference of State Legislatures Annual Meeting and Exhibition

Indianapolis IN

Sponsor: Natl. Conference of State Legislatures

Contact: Same, 303-830-2200; Fax: 303-863-8003

25-28 National Council of La Raza 1999 Annual Conference: Launching a New Millennium

Houston TX

Sponsor: Natl. Council of La Raza (NCLR)

Contact: Same, 202-785-1670 or 800-331-NCLR

Fax: 202-776-1790

E-mail: conference@nclr.org

Web: www.nclr.org/special/conf99

25-28 14th Annual Conference - Working with America's Youth

Minneapolis MN

Sponsors: Natl. Resource Ctr. (NRC) Youth Services;

U. of OK, College of Continuing Education

Contact: Susan Schelbar, NRC Youth Services

918-585-2986; Fax: 918-592-1841

E-mail: ssschelbar@ou.edu

Web: www.nrcys.or.edu

26 Case Management and Harm Reduction

New York NY

Sponsor: Harm Reduction Training Institute

Contact: Same, Sara Kershner, 212-683-2334

Fax: 212-213-6582

27-30 Substance Abuse and Mental Health Services Administration (SAMHSA) 2nd National Conference

Los Angeles CA

Sponsors: SAMHSA; CDC; HRSA; NIH; Public

Health Service Office of Women's Health; other Federal agencies

Contact: Courtesy Associates, 202-973-8657

28 National Technical Assistance Conference Call "Medicaid/CARE Act Coordination"

(for Ryan White CARE Act grantees)

2:00-3:00 PM (EST)

Rockville MD

Sponsor: HIV/AIDS Bureau, HRSA

Contact: Mira Levinson, 617-482-9485

28-30 Getting it Right - A UK Conference of People Living with HIV and AIDS - Shaping the Future of HIV Services

Coventry, United Kingdom

Sponsors: UK Coalition of People Living with HIV and AIDS; Natl. AIDS Trust; The Network of Self Help HIV and AIDS Groups

Contact: Jo Robinson, Natl. AIDS Trust

+01718146729

E-mail: jo.robinson@nat.org.uk

Web: www.nat.org.uk

28 Relocating Therapy: Frontline Staff as Mental Health Service Providers

New York NY

Sponsor: Harm Reduction Training Institute

Contact: Same, Sara Kershner, 212-683-2334

Fax: 212-213-6582

7/29-Comprehensive Review of HIV Management:

8/3 Summer Symposium

Sun Valley ID

Sponsor: Dept. of Medicine, U. of CA

San Francisco

Contact: Continuing Medical Ed., UCSF

Box 0656, San Francisco CA, 94143-0656

7/31-NAPWA Eastern Regional Meeting

8/1 Jersey City NJ

Sponsor: Natl. Assn. of People with AIDS

Contact: Beri Hull or Hector Rivera, 202-898-0414

Web: www.napwa.org

AUGUST

- 2 *Harm Reduction Counseling II - A Two Way Street*
New York NY
Sponsor: Harm Reduction Training Institute
Contact: Same, Sara Kersbnar, 212-683-2334
Fax: 212-213-6582
- 2-4 *National Conference on Health Statistics - Health in the New Millennium: Making Choices, Measuring Impact*
Washington DC
Sponsor: Natl. Ctr. for Health Statistics, CDC
Contact: Same, 301-436-8500
Web: www.cdc.gov/nchswww
- 8-10 *NARMH 25th Anniversary Conference: Creating Visions for Rural Mental Health in the New Millennium*
Bloomington MN
Sponsor: Natl. Assn. for Rural Mental Health
Contact: Lu Ann Rice, NARMH, 320-202-1820
Web: www.nrbarural.org
- 8-13 *97th Annual Scientific Assembly & Exposition of the National Medical Association*
Las Vegas NV
Sponsor: Natl. Medical Assn.
Contact: Same, 202-347-1895; Fax: 202-347-0722
Web: www.nmaonline.com
- 12-15 *1999 Minority Executive Director's Leadership Forum: Challenges for the New Millennium*
St. Thomas Virgin Islands
Sponsor: Natl. Minority AIDS Council
Contact: Same, 202-483-6622; Fax: 202-483-1135
Web: www.nmac.org
- 12-13 *HIV Innovations Along the Border*
Tucson AZ
Sponsor: CODAC Behavioral Health Services, Inc.
Contact: Same, 520-327-4505; Fax: 520-792-0033
- 13-19 *9th International Conference for People Living with HIV/AIDS*
Warsaw Poland
Sponsors: Global Network of People Living with HIV/AIDS; Intl. Community of Women Living with HIV/AIDS
Contact: Conference Secretariat Office, Polish Fdn.
for Humanitarian Aid, +48 22/ 826-06-60
Fax: +48 22/ 826-62-21
E-mail: resaid@waw.pdi.net

- 15-17 *Community Planning Leadership & Orientation Training (CPLOT) Platinum*
Virgin Islands, Virgin Islands
Albuquerque NM
Sponsors: Natl. Native American AIDS Prevention Ctr.; Natl. Minority AIDS Council
Contact: CPLOT Platinum Registration, c/o NMAC, 202-483-6622
Fax: 202-483-1127
E-mail: rcantu@nmac.org
Web: www.nmac.org
- 18 *Harm Reduction with Crack Users*
New York NY
Sponsor: Harm Reduction Training Institute
Contact: Same, Sara Kersbnar, 212-683-2334
Fax: 212-213-6582
- 19 *Science in a Fishbowl*
Boston MA
Sponsors: Natl. Institute of Mental Health; School of Public Health, Boston U.; School of Public Health, Harvard U.; MA Dept. of Public Health; Boston Public Health Commission; American Psychological Assn.; CDC
Contact: Dr. Willo Pequegnat, 301-443-6100
Fax: 301-443-9713
E-mail: wpequegn@nib.gov
- 22-27 *9th Congress on Pain*
Vienna, Austria
Sponsor: Intl. Assn. for the Study of Pain
Contact: Same, 206-547-6409; Fax: 206-547-1703
E-mail: iasp@locke.bs.washington.edu
Web: weber.u.washington.edu/crc/iasp.html
- 25 *The Harm Reduction Voice in Therapy*
New York NY
Sponsor: Harm Reduction Training Institute
Contact: Same, Sara Kersbnar, 212-683-2334
Fax: 212-213-6582
- 26-28 *Connections 99: Finding the Balance - 3rd National Conference for HIV/AIDS Hotlines, Helplines, and Referral Services*
Atlanta GA
Sponsors: American Social Health Assn.; CDC
Contact: Joseph Barna, 919-361-8413
E-mail: josbar@ashastd.org
Web: www.ashastd.org/press/012099.html
- 26-28 *GLMA's 17th Annual Symposium: Taking Care of our Whole Community*
San Diego CA
Sponsor: Gay and Lesbian Medical Assn.
Contact: Same, 415-255-4547; Fax: 415-255-4784

August Continued

8/29-National HIV Prevention Conference

9/1 Atlanta GA

Sponsor: CDC

Contact: www.cdc.gov/nchstp/hiv_aids/conferences/nbpc99.htm

8/30-Adolescent Health Promotion (Training)

9/24 Santa Cruz CA

Sponsor: Intl. Health Programs, Public Health Institute

Contact: Same, 831-427-4965; Fax: 831-458-3659

E-mail: ihp@cruzio.com

Web: www.ihp.org

12-15 12th Annual National Prevention Network Research Conference

Buffalo NY

Sponsor: Natl. Prevention Network

Contact: Sue Carlson, U. of OK; 405-325-1447

E-mail: scarlson@ou.edu

Web: www.nasadad.org

9/13 - Implementing AIDS Programs (English)

10/8 Santa Cruz CA

Sponsor: Intl. Health Programs (IHP)

Contact: Same, 831-427-4965; Fax: 831-458-3659

E-mail: ihp@cruzio.com

Web: www.ihp.org

14-17 Comprehensive Management of the HIV Disease Continuum: A Clinical

Preceptorship for APRNs, PAs and RNs

New Orleans LA

Sponsor: Delta Region AETC, HIV/AIDS Bureau, HRSA; LSU School of Nursing

Contact: Dana Gray-Ward, Delta Region AETC

E-mail: dgray@lsu.mc.edu

15-17 SPNS Cooperative Agreement Steering Committee Meeting

Poster and Panel Sessions (Sept. 16)

(Ryan White CARE Act Special Projects of National Significance Program)

Rockville MD

Sponsor: HIV/AIDS Bureau, HRSA

Contact: Sandy Gamliel, 301-443-3660

E-mail: sgamliel@brsa.gov

16-17 Permanency Planning: Facing Challenges of Children and Families with HIV/AIDS

New York NY

Sponsors: Natl. Abandoned Infants Assistance (AIA)

Resource Ctr.; Leake and Watts Services, Inc.

Contact: Gwendolyn Edgar-Miles, 510-643-7018

Fax: 510-643-7019

E-mail:

gwendoly@socrates.berkeley.edu

16 HIV Prevention Counseling: The Facts

Richmond VA

Sponsors: VA Commonwealth U. HIV/AIDS Ctr.; Mid-Atlantic AETC, HIV/AIDS Bureau, HRSA; Central VA AIDS Resource & Consultation Ctr.

Contact: VCU HIV/AIDS Ctr., 800-525-7605

16-19 6th Annual AIDS Meal & Nutrition Providers' Conference: Food Fight 1999

Atlanta GA

Sponsor: AIDS Nutrition Services Alliance (ANSA)

Contact: Same, 202-289-5650; Fax: 202-842-3323

SEPTEMBER

1-5 2nd Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants

Montreal Canada

Sponsors: Intl. AIDS Society; American Fdn. For AIDS Research; Office of AIDS Research, Natl. Institutes of Health (NIH); Canadian Assn. For HIV Research; CDC; Elizabeth Glaser Pediatric AIDS Fdn.; Fogarty Intl. Ctr.; Global Strategies for HIV Prevention

Contact: Felicissimo & Associates Inc., 514-874-1998

Fax: 514 874-1580

E-mail: globals@total.net

Web: www.globalstrategies.org

5-6 Advances in Pediatric AIDS

Montreal Canada

Sponsor: New York Academy of Sciences

Contact: Same, 212-838-0230; Fax: 212-838-5640

E-mail: conference@nyas.org

Web: www.nyas.org

9-12 Second Millennium Infectious Disease in Corrections; A Coordinated Approach

Scottsdale AZ

Sponsor: Correctional HIV Consortium (CHC)

Contact: Same, 415-439-5285; Fax: 415-439-5299

E-mail: cbc@silcom.com

Web: www.silcom.com/~cbc/index.html

12-14 Community Planning Leadership and Orientation Training (CPLOT)

St. Thomas Virgin Islands

Sponsors: Natl. Minority AIDS Council; Natl.

Native

American AIDS Prevention Ctr.

Contact: NMAC, 202-483-6622; Fax: 202-483-1135

Web: www.nmac.org

16-17 *Chicago National Primary Care*
Chicago IL
Sponsor: *Nurse Practitioners Associates for*
Continuing Education (NPACE)
Contact: *Same, 781-861-0270; Fax: 781-861-0279*
E-mail: *npace@npace.org*
Web: *www.npace.org*

22 *HIV Prevention Counseling: The Facts*
Fairfax VA
Sponsor: *Northern VA HIV Resource &*
Consultation Ctr.; Mid-Atlantic AETC,
HIV/AIDS Bureau, HRSA
Contact: *Shelia Hautbois, Inova HIV Services*
703-204-3776
E-mail: *shelia.hautbois@inova.com*
Web: *www.inova.com*

23-24 *New Challenges for the New Millennium: HIV*
and Adherence, Adolescence & Cultural Issues
Ft. Myers FL
Sponsors: *Everglades Area Health Education Ctr.,*
Inc.; Gulfcoast South Area Health
Education Ctr., Inc.; FL Dept. of Health -
Area 8 Southwest AIDS Network
Contact: *FL Dept. of Health, 561-844-1099 ext.32*

29-30 *HIV Prevention Counseling: The Approach*
Richmond VA
Sponsors: *VA Commonwealth U. HIV/AIDS Ctr.;*
Mid-Atlantic AETC, HIV/AIDS Bureau,
HRSA; Central VA Resource &
Consultation Ctr.
Contact: *VCU HIV/AIDS Ctr., 800-525-7605*

29-30 *HIV Prevention Counseling: The Approach*
Fairfax VA
Sponsors: *Northern VA HIV Resource &*
Consultation Ctr.; Mid-Atlantic AETC,
HIV/AIDS Bureau, HRSA
Contact: *Roy Berkowitz, Inova HIV Services*
703-204-3793
E-mail: *roy.berkowitz@inova.com*
Web: *www.inova.com*

NOTE:
The CDC National AIDS Clearinghouse has a database of
national HIV/AIDS-related meetings. To obtain a copy, call
1-800-458-5231 (TTY: 1-800-243-7012); Fax: 1-888-282-7681;
E-mail: info@cdcnac.org; or visit their web site at
<http://www.cdcpin.org>. This calendar also is available on the
HIV/AIDS Bureau web site: <http://www.brsa.gov/bab>. To have
your activity included on the calendar, contact Kathryn O'Neill
at 301-443-7239, or via E-mail at koneill@brsa.gov.